

operation has been performed often enough to satisfy the most sceptical, and in no single instance has the patient recovered. The last addition to this terrible series of deaths has been made by Rydygier. An account of the case is published by Dr. BIZIEL, in *Przegląd lekarski*, 1885, No. 14. The patient was a woman aged thirty-one. Splenic enlargement had been noticed for about three years. She had pronounced leucæmia. The operation was performed without difficulty, and the patient died in twenty-four hours.

DIAPHRAGMATIC HERNIA.

An interesting case of this somewhat rare rupture is reported by Drs. GALASSI and TENERI, in *Lo Sperimentale*, 1885, No. 3. The patient was a woman, aged twenty-eight. She was seized with sudden abdominal pain, followed by vomiting and constipation. The examination of the thorax (which must have been very loosely conducted) revealed nothing. Both the right and the left side of the colon were found to be full. The symptoms of intestinal obstruction increased, and on the seventh day of the disease laparotomy was performed. There was no peritonitis. The result of the laparotomy was that the cause of the obstruction was not detected. The patient died on the following day. At the time of her death there appears to have been no suspicion that she suffered from diaphragmatic hernia. Such a rupture, however, was revealed at the autopsy; and was apparently of congenital origin. The transverse colon was found in the left pleural cavity, and had become occluded by kinking. It is to be regretted that the patient was not subjected to a more careful examination, and that the laparotomy had not been more systematically carried out. This is probably the first instance of laparotomy for diaphragmatic hernia.

RESECTION OF INTESTINE FOR WOUND.

The operator was Dr. KWIENCINSKI (*Przegląd lekarski*, 1885, No. 5). The patient, a man aged twenty, was stabbed in the abdomen. Through the wound a metre of small intestine protruded, in which four wounds were discovered. Two of these wounds were closed by suture, but the remaining two were so close together that suture was impossible. The involved segment was therefore resected. The divided ends were united by suture, the bowel returned, and the abdomen closed. The patient made a good recovery. This case makes another link in the chain of argument for the treatment of these cases by resection—a treatment that has been so admirably illustrated by the practice of Bull, of New York; Kocker, of Berne; Annandale, of Edinburgh, and others.

SARCOMA OF THE BOWEL.

Dr. BESSEL-HAGEN (Virchow's *Archiv*, Bd. xcix. Heft 1) reports the case of a boy aged seven, who, some little time after having received an injury to the abdomen, developed a tumor about the damaged spot. He rapidly became marasmic, and died in four months. The autopsy revealed a sarcomatous growth in the jejunum of the size of the fist. It was of the small round-celled variety, and sprang from the submucous tissue. There were

many secondary deposits. The case is of interest in connection with the supposed influence of the injury and the rapid progress of the disease, apart from the great rarity of these neoplasms in the bowel.

THE RADICAL CURE OF HERNIA.

MR. KEETLEY (*Brit. Med. Journal*, September 19, 1885) advocates a modified form of what is known as the injection treatment. The treatment of reducible ruptures by injecting some irritant fluid into the tissues about the hernial orifice was first introduced by Dr. Heaton in 1832, and subsequently advocated with obtrusive vigor by Dr. Warren. The measure never appears to have taken any hold of the surgical mind in this country. In Germany it has been adopted, and has received a considerable number of supporters. Last year Dr. Schwalbe published a treatise (*Die Radikale Heilung der Unterleibsbrüche*) advocating this measure. It appears from this paper that the treatment must extend over a period varying from two to twelve months, and that on an average twenty injections are required in each case.

Apart from the tedious character of the proceeding, these operations are attended with danger, in that the injection is made blindly, and no security is offered to insure the non-entrance of the fluid into the sac or into the peritoneum. Mr. Keetley's procedure removes the principal objections brought against the injection method. He does not make his injection blindly. He cuts down upon the inguinal ring, and thrusts a probe through the undivided inter-columnar fascia into the inguinal canal. Along the probe is introduced a canula, and through the canula the fluid is injected into the canal. Mr. Keetley uses a freshly prepared concentrated decoction of oak bark. After the injection, the pillars of the external ring are brought together by two catgut sutures. Mr. Keetley has operated upon eleven cases, and in two only has the result "fallen short of complete success." All these operations have been performed during the past twelve months, and it is obvious that sufficient time has not yet elapsed to allow of the value of the operation being judged. It is difficult, also, in these cases, to separate the effect of the injection from the effect of the closure of the external ring. In cases in which injection alone has been used, repeated injections have been required to effect a cure, and little has been done by one application.

THE MECHANICAL CLOSURE OF ARTIFICIAL ANUS.

DR. TELEKY (*Wiener med. Blätter*, 1885, No. 9) writes upon this subject. It must be allowed that the various pads, trusses, and receptacles that have been devised for the artificial anus after lumbar colotomy do not very efficiently fulfil their intentions. In actual practice the patient very commonly discards them all, and adopts some simple arrangement of his own. Dr. Teleky has added another apparatus to the list. It consists of two India-rubber balls, which are united by a short, thick, narrow and solid stem. One of the balls lies within the gut, and serves to close its lumen; the other, the larger, lies upon the wound, which it covers and protects. The stem occupies the sinus between the skin-wound and the gut lumen, and must, obviously, be very short. The balls are introduced empty and are inflated *in situ*. They